MEDICAL HISTORY

Patient Name:_____ Age:_____ Today's Date:_____

Name you prefer to be called if different from above:_____

How did you hear about us _____

Main reason for visit _____

Primary Care Physician:_____ Phone:_____ Fax:_____

Medical History: Please check any of the following illnesses/diagnoses you have had problems with

☐ High Blood Pressure	☐ Depression	☐ Urinary Incontinence
☐ Diabetes	☐ Anxiety	☐ Osteoporosis/Osteopenia
☐ Cancer (list type)	☐ Thyroid Disease	☐ Seizures
☐ Mitral Valve Disease	☐ High Cholesterol	☐ Arthritis
☐ Chest Pain	☐ Stroke	☐ Tuberculosis
☐ Heart Attack	☐ Kidney Disease	☐ Other Lung Problems
☐ Asthma	☐ Vein Trouble	☐ Obesity

☐ Other_____

Have you had any of the following immunizations? (Please list date)

Flu shot _____ Pneumovax _____ Hepatitis B _____

Surgical History: Please list any procedures or operations you have had (Don't forget to include cesarean sections, wisdom teeth, D & C, any abdominal, vaginal or limb surgery, colonoscopy or sigmoidoscopy.)

Date	Operation	Date	Operation

Medications

Do you have any allergies to medicines, latex, X-ray dye or other substances? ☐ Yes ☐ No

(If so, please list name of medicine and type of reaction)

_____

What medications (prescription, over the counter, vitamins, herbs, etc) do you take? (Please include dose and frequency)

_____

_____

_____

Social History Please check where applicable

No	Yes	In Past	
☐	☐	☐	Tobacco use: _____ packs per day for _____ years. Do you want to quit? _____ Quit date _____
☐	☐	☐	Alcohol use: _____ drinks per week.
☐	☐	☐	Illegal drug use: type:_____
☐	☐	☐	Are you working? What do you do?_____
☐	☐	☐	Do you wear seatbelts?
☐	☐	☐	Do you exercise?
☐	☐	☐	Have you ever been mentally, physically or sexually hurt by your partner or another?

How would you describe yourself? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnered

Family History Please include any cancer (especially breast, ovarian, uterine, cervical and colon, including age at diagnosis), heart disease, diabetes, drug or alcohol addiction, bleeding diseases or emotional/mental illness in the following family members

Mother _____